IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY
Civil No. 2:16-cv-08637-CCC-MF

IJKG, LLC, doing business as CAREPOINT HEALTH - BAYONNE MEDICAL CENTER,

Plaintiffs,

v.

UNITED HEALTHCARE SERVICES, INC., et al,

Defendants.

TRANSCRIPT OF PROCEEDINGS
- Motion -

Newark, New Jersey
May 2, 2018

B E F O R E:

THE HONORABLE CLAIRE C. CECCHI,
UNITED STATES DISTRICT JUDGE

A P P E A R A N C E S:

K&L GATES LLP
BY: GEORGE P. BARBATSULY, ESQ.
STACEY A. HYMAN, ESQ.
Attorneys for Plaintiffs

McELROY, DEUTSCH, MULVANEY & CARPENTER, LLP
BY: GEORGE C. JONES, ESQ.
- and -
DORSEY & WHITNEY, LLP
BY: SHANNON L. BJORKLUND, ESQ.
Attorneys for Defendants

Pursuant to Section 753 Title 28 United States Code, the following transcript is certified to be an accurate record as taken stenographically in the above entitled proceedings.

S/WALTER J. PERELLI

WALTER J. PERELLI, CCR, CRR
Official Court Reporter

THE DEPUTY CLERK: All rise.
THE COURT: Welcome, everyone.
MR. JONES: Good morning, your Honor.
MR. BARBATSULY: Good morning.
THE COURT: Good morning.
We're here on IJKG, LLC v. United Healthcare Services, Inc., and the Docket Number is 16-8637. We're here today for purposes of hearing oral argument on a motion to dismiss.
So let's get your appearances first and then we'll proceed. Thank you.
MR. BARBATSULY: Good morning, your Honor. George Barbatsuly from K&L Gates, attorneys for the Plaintiffs.
THE COURT: Good morning. How are you?
MR. BARBATSULY: Good. How are you?
THE COURT: Good.
MS. HYMAN: Good morning, your Honor. Stacey Hyman, K&L Gates, attorneys for Plaintiffs.
THE COURT: Thank you so much.
MR. JONES: George Jones. McElroy, Deutsch, Mulvaney & Carpenter, for Defendants. And also with me today is my co-counsel, Shannon Bjorklund, from Dorsey & Whitney.
THE COURT: Thank you so much.
Everyone, have a seat. So we have a motion to dismiss today. I know that there was some query as to weather the ELMO was working. Let's talk about what we're going to be using

before we start and then you'll begin your oral argument.

Does anyone need to hand anything up before we start?

MS. BJORKLUND: Your Honor, Shannon Bjorklund.

I have a couple of exhibits which are just excerpts of a couple of the exhibits to the Complaint.

THE COURT: Okay, great. You can provide those. Thank you.

Very well. At this point, let's begin. How would you like to proceed?

MS. BJORKLUND: Thank you, your Honor.

Again, my name is Shannon Bjorklund, counsel for Defendants.

In this lawsuit there are 11 -- if your Honor is okay? I will proceed with argument.

THE COURT: Definitely. Go right ahead. And I've read the papers, so I'm familiar with the case. So you can go ahead.

MS. BJORKLUND: Thank you.

THE COURT: Thank you.

MS. BJORKLUND: In the lawsuit there are 11 counts that are premised on one core assertion: That the out-of-network CarePoint Hospitals enforce United Health to pay whatever rates CarePoint chooses to charge. But neither the Plan terms, nor ERISA, nor state law permits an out-of-network provider to dictate the level of benefits provided in an ERISA

plan.

THE COURT: Although, let me stop right there though.

MS. BJORKLUND: Correct.

THE COURT: Are they saying that they need a specific amount or are they asking for the reasonable fees to be paid?

And the way that I see this being alleged is that they had services that were provided to patients, coverage was provided by the Defendants and then later some moneys that were paid were sought back. Are we in agreement with respect to that?

MS. BJORKLUND: That's correct, your Honor. So that the primary dispute here is whether Plaintiffs are entitled to more, in addition to the money that they have already received.

THE COURT: Okay. Let's hold for one moment.

Let me hear from the Plaintiff. How are you determining how much should have been paid versus what was asked to be sort of paid back? Because Defendants are saying you're setting a very high bar in terms of payment. But how do you determine what you believe the payment should be?

MR. BARBATSULY: So, we allege on information and belief that all of the Plans require United to reimburse the CarePoint Hospitals for their billed charges, less applicable in-network patient responsibility, and that's for emergent care. And that --

THE COURT: I'm sorry. So it's bill charges, less

applicable?

MR. BARBATSULY: The in-network -- the patient responsibility that a patient -- and this is for emergency care. So if a patient is going to seek treatment in an emergency room, the patient doesn't have a choice as to whether to -- which hospital to select. And so when a patient presents at an out-of-network hospital -- typically this is reflected in plans, it's reflected -- and coverage mandates that we cite the complaint in New Jersey -- typically that requirement is that the Plan must make the patient whole, which even if it means paying the provider's bill to charges minus the patient responsibility that the patient would have otherwise had, had they presented to an in-network hospital, such as deductibles, co-payments and co-insurance.

We also allege that in the case of elective care, the Plans typically require reimbursement at usual, customary, and reasonable rates. And we allege at paragraph 90 of our Complaint that our charges are consistent with usual, customary, and reasonable.

Now, I recognize United disputes that, but that's an issue that I don't think is before the Court as far as whether our charges are reasonable, customary, and usual.

We do have some Plan language that we attached to our Complaint that we think supports our allegations. Exhibit E is one Plan. It says, where there is no contracted rate with an

out-of-network provider, eligible expenses is determined based on competitive fees in that geographic area;

Exhibits L and O -- this is what I was talking about with the emergency mandate -- if the subscriber is entitled to full coverage for an emergency room treatment other than a nominal co-pay, which is waived if the patient is admitted to the hospital within 24 hours, and for elective services, a percentage of the provider's bill charges;

Exhibit P, another Plan that we rely on: Depending on the level of coverage, a $100 co-payment is required, and if the United subscriber is admitted the Plan covers 100 percent of the facility and physician cost to 60 percent of the reasonable, customary charges for the emergency treatment.

So, we recognize that Plans vary in terms of coverage, but we allege that in all respects -- and based on the Plans that we've seen and based on information and belief, they have not honored those obligations in part -- and in large part because of their conduct after paying the claims to begin with -- and that's another violation of the Plans, your Honor, which is that they simply offset future claims which we contend in our Complaint is not permitted under the Plans.

THE COURT: Okay. Let me turn back to the Defendants.

Okay. Go ahead.

MS. BJORKLUND: So, your Honor, what I hear Plaintiff saying is that they are comparing their bill charged to the

amount paid, not something like a reasonable and customary rate. I understand Plaintiffs make one vague assertion in their Complaint that all of their rates are their usual and customary rates, but that simply is insufficient under Twombly to state a plausible claim for relief.

I would point your Honor to Footnotes 13 and 14 of our motion. We also cite Plan terms that describe the varying levels of benefits among the different Plans. And this is one reason it's very important to look at individual Plans and individual claims to determine whether there is any plausible claim.

So, for example, in Exhibit L, the Plan says: (Reading) Our allowed amount is not based on UCR and the non participating provider's actual charge may exceed our allowed amount.

That Plan very specifically draws a distinction between "usual and customary" and the Plan's reimbursement rate.

Another example would be exhibit -- the excerpts that I provided the Court with Exhibit P. So if you specifically turn to page 29, this is a Plan that does describe fees in relation to reasonable and customary rates, but again notes that a provider's bill rate may not necessarily be a reasonable and customary rate.

Now, Plaintiffs don't make any attempt to give

specific factual allegations as to how their rates match up to a reasonable and customary rate. For example, they don't cite any comparative studies, they don't cite any --

THE COURT: Although would that be for an SJ as opposed to a motion to dismiss?

MS. BJORKLUND: So, your Honor, at the pleading stage in an ERISA case, often you have cases, for example, Broad Surgical, where you have to cite specific plan terms to determine that the alleged service is actually provided and is covered under the plan. And here we have a slightly different question. But again --

THE COURT: Here I would imagine both sides agree everything is covered under the Plan. It's the payment.

MS. BJORKLUND: I slightly dispute that. We're talking about the lion's share of disputes which relate to usable and customary rates, but there are also a number of other types of disputes. For example, incorrect interest payments, billing errors, duplicate submittals. And in the attachments to the Complaint it indicates that there are a number different reasons for denials. But I agree with your Honor that the majority, and the ones we're primarily talking about here, the dispute is not coverage, the dispute is whether Plaintiffs are entitled to additional benefits under the Plan over and above what they've already received.

THE COURT: Okay. So the dispute is regarding the

payment here by and large. Why isn't it sufficient what they've already alleged?

MS. BJORKLUND: Because, your Honor, they have already been paid. If you have a situation where a specific type of service is covered under a plan and there's been no payment, that states a plausible claim under ERISA. But when you have a situation where a claim has already been paid, to state a plausible claim that they're entitled to something more, they have to compare what they've been paid to what is actually dictated under the terms of the Plan.

Some of these plans also determine benefits with regard --

THE COURT: Is that something that they have to ultimately prove, or is that something that you're saying they need to allege?

MS. BJORKLUND: Both. Both, your Honor. So I think they do need to allege --

THE COURT: Because I think that they've alleged that they're seeking reasonable payment, are they not?

Let me hear counsel.

MR. BARBATSULY: We do allege that we're seeking -- typically -- we allege that the Plans as written and as some of the language that I cited to your Honor, we allege that the Plans do in the emergency context require our billed charges. But we separately allege that what we -- and with respect to

ERISA elective services -- that the Plans require usual, customary, reasonable, and we allege that our charges are usual, customary, and reasonable for purposes of this motion. Your Honor needs to accept that fact as true. That's an issue that can be explored in the course of discovery.

But in many cases, not only -- and I would somewhat disagree with the characterization that this is simply a claim for more. This is a claim where payments were made and then payments were offset against future claims. So essentially, for a million dollars worth of our charges they've actually recouped that. So in many cases we've gotten zero or almost zero payment.

So there are several violations that we're relying on:

(a) that the result of the offset is that they're drastically underpaying as they're required under the Plan;

(b) we contend that they're not even allowed to offset in the way they did. Because the way the offset language works in the Plans is they have to offset against that Plan, and they're just basically taking money back that is related to future claims that is not derived from this particular claim for benefit.

So we have a number of violations that we contend are plausible, one of which, you know, back to your Honor's point, is that we have not been reimbursed as required by the Plans, and that derives in part from the significant offsets that were

taken.

THE COURT: Let me ask counsel for the Defendant: In terms of the offsets, how does that come about? Why are the claims paid initially and then there's a request for offset?

And I realize this is getting a little afield of where we're at. But just so I understand the background of what your position is on that, if you could explain how the process works in terms of why there is a request thereafter for an offset when claims were initially paid.

MS. BJORKLUND: So, your Honor, I'll describe this in a very high level generally. It may not be a hundred percent accurate for each of the claims at issue.

THE COURT: That's fine.

MS. BJORKLUND: So, in general, for these emergency room claims, a claim is submitted and payment is issued very quickly. And in these instances it appears that the payment was for the full billed amount.

Now, at a later point in time there was an audit done to determine whether these were actually being appropriately paid, and the audit uncovered a number of issues. So some were more of the sort of technical administrative issues that I mentioned, like interest calculations or somebody was no longer a Plan participant at the time of the claim, but others related to kind of an assessment of the reasonable and customary rate issue or the actual allowed bills.

I would say in counsel's last statement I heard a couple of things that were new that I have not seen in the Complaint, and I just -- they fit into this so I would like to just address them here.

THE COURT: Go right ahead.

MS. BJORKLUND: So one is the allegation that offsets are made against other Plans. That's nowhere alleged in the Complaint. I haven't seen any allegation of that, I don't have any specific evidence on that. And I think that's really not an issue that's before the Court for this motion to dismiss.

The other statement that was made is that there is zero or almost zero payment on a number of claims. And again, I don't think that's something that was pleaded in the Complaint.

In the Complaint the allegation is that there was a partial payment, and according to Plaintiffs it should have been higher. Right? And that dictates an analysis of the Plan terms. For example, under a Plan allowing 140 percent of Medicare rates, there's no allegation that their rates match 140 percent of Medicare rates, which would justify an increased payment over what has already been done.

THE COURT: If you're measuring it against Medicare rates, why was the claim paid initially at a higher rate?

MS. BJORKLUND: So, your Honor, most of these Plans have multiple different criteria on which they are paid. So it

could be 140 percent of Medicare rates, or an amount as agreed upon with an in-network provider, or there might be a gap methodology. So it's not always immediately apparent from receiving a claim whether -- you know, which one of those three metrics you would apply.

But as far as kind of what the thinking was in the initial claim process, unfortunately I don't know, I can't tell your Honor the answer to that.

THE COURT: So what happens with the patient here? They have their claim paid and then months later or years later they're told that it wasn't paid and they'll have to provide money back? How does that work?

MS. BJORKLUND: Well, that is where some of the state laws kind of come in and are a bit interesting here.

So, there are ERISA plans, and there's preemption for many ERISA plans, and then there could be -- although Plaintiffs haven't alleged the actual existence of -- state law claims. And so that's where the New Jersey statute saying that patients have the right to be free from balance billing comes in. But again, that relates to kind of the non ERISA plans that aren't really what we're talking about here. And I think that really is an issue as between kind of the patient and the provider.

I would take slight issue with the fact that there's no choice of which hospital to go to during an emergency.

Obviously if you're being picked up from an ambulance you may not have a choice, but patients and people do sometimes exercise a choice in which hospital they choose to seek care from even in the emergent setting.

THE COURT: But generally I think what we're talking about is you're involved in an emergency, you end up at the hospital.

MS. BJORKLUND: Correct.

THE COURT: You're not charting this out for weeks, you're not determining which one to go to. It's an emergency event, you're in a rush, you're at the hospital.

MS. BJORKLUND: Correct. And you go, and then at some point you may get a bill for that service just as you would for an urgent care service or a doctor service.

I'm thinking of my own personal experience. I had an incident with my 2-year-old last summer, and I did receive a bill after the fact for emergency room treatment after offsets had been made for insurance adjustments.

THE COURT: What happens then to the patient with the offset thereafter? So three years down the road after you thought everything was paid, then do you get some request for payment back?

MS. BJORKLUND: So, what happens is the communication comes from United or the provider. And in this instance I submitted with my declaration one example of an explanation of

benefits. So it would come after the fact in this instance and it would say, you know, we redetermined, and this is the amount of money that is due to you under the plan. Right? But the money is paid directly to the provider.

And so what happens after that is a matter between the patient and the hospital or the provider. And so sometimes providers don't bill the additional amount, sometimes providers have an adjustment or have some other rates and some other kind of rate structures that they look at. But in any event, that's not a question of what is due and owing under the terms of a plan that the patient is a member of where the plan terms are dictated by the contract, which is the coverage. And what happens as to any rates that exceed that is really an issue between the patient and the provider.

THE COURT: Okay. Thank you.

You can proceed. I know you have a number of arguments that you would like to make, so go through them.

MS. BJORKLUND: Okay. So, your Honor, if I could, I would like to turn to exhaustion. This case is before the Court even though the ERISA appeals process has not yet played out. Congress mandated a specific appeal process, and in this instance for the four exemplar Plans that have been referenced there's a two-step process. There are two separate appeals that are done by the Administrator prior to seeking Court intervention as a way to narrow issues, avoid overburdening the

Court, streamline it and keep kind of the administrative cost of the Plan well in check.

Here, CarePoint is relying on a few lines in a few emails as supposedly satisfying the appeal process for 382 separate ERISA claims, and that's very far from the dictated ERISA appeal process. And I would submit that the pleading in the Complaint makes clear that this process was not actually used and obtained, and so therefore the Complaint should be dismissed.

This can happen at a motion to dismiss stage. Sometimes it is at summary judgment. But when the Complaint makes clear that this process did not occur, a court can dismiss a claim for failure to exhaust, in which case this dispute goes back to the patient, or in this case if there is a valid assignment, the provider and the insurer and the Claims Administrator, and they resolve the appeal process, hopefully narrow or eliminate issues and then it's presented to the court in due course if necessary, or not at all.

THE COURT: Although here when they've alleged that they've received a final adverse decision, why is that not enough to let them proceed on that, especially in light of case law that finds that exhaustion is most often something that's dealt with in this context in a summary judgment context?

MS. BJORKLUND: So, in some cases exhaustion -- there's a futility issue and that can be more factual and be

resolved later. I think in this instance they've alleged certain acts that they contend were exhaustion and then they've attached that correspondence. And a bare look at the correspondence shows that is not even part of the ERISA process.

I also submitted in my declaration one of the adverse benefit determinations for a patient which actually postdated the process. So as we tried to explain in our brief, there's the provider dispute process, and then there's a separate ERISA patient process. So everything that they have attached exists in the context of the provider process and there's simply nothing that even is a part of the ERISA appeal process. So --

THE COURT: I think they allege futility too, do they not?

MS. BJORKLUND: They do allege futility. And their argument is interesting. So there used to be more than 382 claims at issue and they disputed some during --

THE COURT: I think you resolved ten of them. Is that correct?

MS. BJORKLUND: Correct, correct.

And so the record demonstrates that communication, even when it's not a full ERISA formal request, has caused United to change its position in certain instances and really reconsider the claims. And so I would say that demonstrates conclusively that there is no futility in this instance.

THE COURT: Okay. Let me hear from counsel.

MS. HYMAN: Your Honor, good morning.

THE COURT: Good morning.

MS. HYMAN: Yes, we do plead in the Complaint at length and provide examples of the futility in this instance. But counsel for Defendants also forgets that there is a regulation that controls ERISA notice and appeal procedures, and that regulation, 29 CFR 2560.503-1, is triggered when an adverse benefit determination is sent to either the member or the provider. And under the regulation, an adverse benefit determination is defined as a denial, reduction, or termination of, or a failure to provide or make payment, in whole or part, for a benefit. And this Court in Premier Health v. United Health Group has held that all repayment demands constitute an adverse benefit determination.

So that then triggers ERISA requirements that would require Defendants to send specific information to the provider. And under Section (g) of the regulation, that would be a specific reason or reasons for the adverse benefit determination that are presented in a manner calculated to be understood by the claimant, and also include a reference to the specific Plan provisions, a description of any additional material information necessary for the claimant to perfect the claim and other requirements as well. And then on appeal, Section (h) requires certain information be provided, including

for group health plans, that they have 180 days to appeal.

And we had attached and pleaded with specificity really specific examples, such as for Patient 1 in Exhibits G, H and I, we pleaded that in response to an overpayment demand for $341,000 of the $358,000 for emergent care, they sought a recoupment of that amount, and an email was sent to appeal that. They accepted that email as an appeal and responded that the appeal -- the decision was upheld. And then there was a letter attached to that which was an appeals resolution letter dated 9/30/2015 that stated: (Reading) We find the overpayment refund request remains valid. The details of our decision are explained on the attached list.

Then they say as the reason, they state: "The executive decision to pay the claim was made at the MNRP rates."

In that letter they provide no explanation of the basis for what their executive decision was, what the MNRP rate is; there's no citation to a plan provision permitting that decision; there's no citation to any internal policy or protocol; and no time frame to appeal further. All it says is: "Your prompt attention to this matter is greatly appreciated. If a response is not received, Oxford Health Plans may offset future payments by the refund amount requested."

We then appealed again. And on 10/27/2015, Exhibit I, again they upheld the appeal decision and they provide the

exact same explanation and no further explanation except for that: "If CarePoint Hospitals seek to arbitrate, they may seek so within 90 days."

So again, this demonstrates the futility of any further appeals. They received two appeals that state the same exact information, and it demonstrates their failure to comply with the regulations. And these were exemplar claims that we explained in the Complaint.

And as far as the futility argument made by counsel that the ten claims were later withdrawn after the appeals process, in the first instance initial letters were sent to the hospital that the hospital never received. They suddenly were receiving final determination letters and called and asked for information and for the letters to be sent. They sent a spreadsheet and they asked if they could have more information soon after seeing the spreadsheets, which I believe were sent on October 6th.

On October 12 an email was sent by Plaintiffs' counsel requesting additional time to research the claims and for more information. They were told this would not stop the recoupments, and they recouped a million dollars worth of claims.

So whether or not ten were later withdrawn just shows their inconsistent application in the appeals process, because 423 claims were not in their asking for $2 million in total --

THE COURT: Okay. Thank you.

And I'm back to this in terms of the Defendants: If we're talking about futility and we're talking about exhaustion, against that backdrop how is that something we would be dealing with on a motion to dismiss? There is a wide array of cases that have pronouncements about reserving until the summary judgment stage on that issue. Why shouldn't we have a further development here?

MS. BJORKLUND: So, your Honor, in sum instances I certainly agree that summary judgment is the more appropriate place for certain questions of exhaustion. But I would point the Court to the American Chiropractic Association case, and specifically I believe it's Footnote 5, we cited it in our brief, and that footnote notes that when the pleadings and the documents incorporated by reference into the complaint make clear that there has not been exhaustion, it can properly be resolved at a motion to dismiss.

THE COURT: Although they're arguing it's exhaustion. She's just gone through the details --

MS. BJORKLUND: Right.

THE COURT: -- of why she believes it to be exhaustion. They have alleged and presented materials regarding exhaustion, so then I'm not sure how we fall within the motion to dismiss rubric.

MS. BJORKLUND: Your Honor, I would say part of this

is more of a legal question. I think counsel's reference to an arbitration or an ability to seek arbitration is really telling. That indicates that this is part of the provider communication process in which a provider and United may enter into arbitration to resolve the agreement amongst themselves, the contract -- the relationship amongst themselves, but it's separate from the relationship between United and the patient.

And so I would submit that they can't point to communications that are really entirely separate from the ERISA congressionally-mandated appeal process to plead that exhaustion has occurred. I would also note the Plan terms have specific rules for what type of information has to go into an appeal of an adverse claim determination. And to give one example, I believe, your Honor, it's Exhibit L, and on page -- it's ECF page 89, it talks about the appeal process.

Your Honor, I'm sorry, I have the wrong page.

But I do know that that and other plans dictate certain things that need to be part of the appeal. For example, patient name, date of service, specific information, and any factual information that the patient wants to submit in order to jump the claim.

THE COURT: Isn't that something that can be developed through discovery? They've already alleged it, and they have in their pleadings contentions regarding utility and exhaustion. And if we're talking about factual scenarios with

the patients and so on, isn't that something we're going to get to in discovery? And I don't know what's going to happen at that stage, but isn't that more appropriate given what we have here before us?

MS. BJORKLUND: So, your Honor, I make two points on that. First of all, the exhaustion requirement would really be meaningless if it was always pushed to summary judgment. The purpose of it is to prevent --

THE COURT: It sounds like we would actually have to parse through this complicated background in order to actually come to some sort of conclusion as to what has occurred. I mean, they've alleged exhaustion.

Let me hear from the Plaintiffs on this, please.

MS. HYMAN: Yes, your Honor.

Exhaustion is an affirmative defense. And just because Defendants' counsel argues in their brief that there is an appeals process that is not an ERISA appeals process doesn't make it so. The cases that deal with this focus on function and not form. And their argument that there was an arbitration offer in one of the letters does not make it compliant with ERISA. They do not comply with ERISA requirements after providing an adverse benefit determination.

And in their brief they argue that there was no adverse benefit determination letter even sent because the letters did not contain equivocal language. And the case they

cite to in support of that argument does not even deal with a recoupment demand but is a partial denial of a claim. And they also cite to our cases in our opposition and say that they didn't deal with the specific type of communication that would be an adverse benefit determination. But again, all of those cases dealt with the function over form of the type of benefit that was being recouped and decided that it was -- the demand itself was an adverse benefit determination.

So once that adverse benefit determination is sent to the provider or the member, that triggers these requirement under ERISA that Defendants just failed to comply with. And therefore, based on the exception in Section (f) of the regulation, that should be sufficient enough for Plaintiffs to be excused from the exhaustion requirement at this stage.

THE COURT: Although I do note on page 33 of your pleading you do have a section, that "CarePoint Hospitals exhaust available appeals remedies." Correct?

MS. HYMAN: Well, we exhaust them as much as we could.

THE COURT: Meaning even though it's a defense, you have actually gone through exhaustion?

MS. HYMAN: We have attempted to do so. And in the argument that we sent an email for one of these claims for a substantial amount of money that Patient 1's claim, that was accepted as an appeal. And so when we asked for additional time after they failed to send us the initial letters and we

pled that they could not prove that they sent them in the first place, they refused and almost immediately started recouping funds. So, you know, we then tried to appeal them. And in many instances we received these appeal resolution letters that basically stated "We uphold the decision," and provided no additional information. Again, no appeals information, no, you have 180 days to appeal.

Frankly, the attachment to the motion, Exhibit 1, was sent in March of 2016, months after the second denial for Patient 1 with an October 27th, and it states that the patient is now responsible for the full $360,000 and it says: "Your Plan paid negative $341,359 because it already recouped that money wrongfully."

And the fact is, that this cannot cure their failure to comply with the regulation in the first instance.

THE COURT: Okay. Thank you.

MS. BJORKLUND: Your Honor, I would like to point out that in this instance United was providing more than the required number of appeals. So first, United engaged in a provider process beginning with CarePoint during its audit investigation. I believe one of the communications says: "Please provide us your input otherwise our audit results will become final."

And then once that audit investigation and provider communication was complete, there was an AOB issued to the

patient.

So again, we have portions of communications that related to a relationship between a provider and United, and then other communications regarding an ERISA-mandated appeal process that relates to United and the patient, and what the AOB that was submitted with the declaration attached to our motion contains. And so it makes sense that that was later, that that was after the communications with the CarePoint Hospital because United actually engaged in two rounds of communication.

And CarePoint can't simply avoid -- if it's going to stand in the shoes of the patients, CarePoint can't avoid the ERISA-mandated appeal process in order to resolve any claims that can be resolved before presenting them to a court. And the fact that United gave them addition opportunities to provide input doesn't eliminate the ERISA requirement.

THE COURT: Okay. Any response to that?

MS. HYMAN: Whether or not they provided us with additional appeals processes is irrelevant because they came back time and time again with the exact same reason for denial which didn't provide any information that would have provided any meaningful review process for Plaintiffs. Saying the same thing three times for one patient is not going to provide any more information for us to understand why this benefit wasn't paid at the emergent level when this patient presented to the

emergency room. And the Affordable Care Act requires that the highest of three rates which would be the reasonable and customary or what the Plan pays, the in-network or the Medicare rate would have been paid, and then they recouped nearly 95 percent of that claim. So their explanation wouldn't have provided that. That's a perfect example of the futility of any efforts made at that point to continue on with any further appeals.

THE COURT: Okay. Anything else on the futility exhaustion? Otherwise I would like to focus on standing for a little bit.

MS. BJORKLUND: Your Honor, we can proceed to standing.

THE COURT: Excellent.

MS. BJORKLUND: By standing I assume you mean the assignment --

THE COURT: Standing of the assignment, yes, and anti-assignment, waiver, all of those arguments.

MS. BJORKLUND: Okay. I'll start unpacking the --

THE COURT: Okay. Thank you.

MS. BJORKLUND: Your Honor, I think the high level point to keep in mind with this whole assignment question is that when a patient assigns a right, the patient no longer holds that right anymore. And so it's important to read assignments very carefully and very narrowly with the view of

protecting the patient's right and the patient's ability to bring a lawsuit or a legal claim, especially when there's an ambiguity.

So here there is, we contend, an ambiguity in the assignments in that they assigned certain rights, they purport to assign certain rights, but then they also state that the provider is acting as an authorized representative. Now, by definition, an authorized representative is representing the patient who still holds the claim.

And I think this is particularly important with respect to the ancillary ERISA claims, the (a)(2) and (a)(3) claims which are Counts 2 and 3, and also the state law claims. And I think one thing to kind of keep in mind is: Does this assignment unambiguously give up a patient's right to sue United for breach of fiduciary duty?

That is the type of claim that's not easily cordoned off or split. So a claim for benefits, you may go to the doctor for emergent gallbladder surgery, to use an example from the Complaint. That's one discrete claim for benefits and you could understand assignment of that to a provider. But an (a)(2) or an (a)(3) claim is broader relief that applies not only to that claim for benefits but to all other claims for benefits for that particular patient and all other Plan members.

And so, in the course of reading whether an assignment

is ambiguous or not, the context is very important as to: What right is the patient giving away? Is the patient giving away a right to a New Jersey Consumer Fraud Act case for any claims related to the CarePoint Hospitals? Is the patient intending to give away its right to sue United for a breach of fiduciary duty and obtain certain relief on behalf of the Plan?

So that's kind of the first step of ambiguity. And we contend that the assignment is ambiguous and so therefore shouldn't be construed. And I will acknowledge that the calculus is different as to Count 1, the claim for benefits, than it is as to all the other claims. We still think we're right, but I do acknowledge that the calculus is different.

THE COURT: Okay. And if we're looking at intent to assign rights, is that something that should be decided at the motion to dismiss stage? If you're saying there's no clear intent, is the Court supposed to construe that?

MS. BJORKLUND: No, your Honor. I'm sorry, I spoke imprecisely. I think it's a legal question by looking at the face of the assignment itself, and the legal question is: Does it unambiguously assign a right?

And the point I'm making is that these agreements do not unambiguously assign a patient's right to sue for (a)(2) or (a)(3) breach of fiduciary duty, other breach of duties under the Plan, or the various state law causes of action.

Unless there are questions on that, I'll move on to --

THE COURT: No. I'm thinking ahead in terms of, I know you have a twofold argument with respect to the assignment, whether certain rights were withheld and whether certain rights were actually given, and you're saying there's a conflict between the two in terms of being an authorized representative and purportedly assigning rights. And I know you rely on a case in your papers, I believe it's MHA, LLC.

Do you have anything else besides that case to support your position? And I know you're advocating that case -- I'm not sure exactly how that applies at this point -- but is there anything further that you would like to advance on that?

MS. BJORKLUND: Well, let me provide more context, your Honor.

So, there are a number of cases, and I'm taking one of them, a number in New Jersey in the Third Circuit, that make the point the once a right is assigned it no longer belongs to the patient. There are also a number of cases saying that when there's an ambiguity, the right remains with the patient, or the person.

I agree with you, the MHA case doesn't address this precise argument. In fact, I'm unaware of any case that specifically addresses this precise argument and, yet, I think the underlying contractual interpretation principles are clear.

THE COURT: Let's hear from the Plaintiffs on this.

MR. BARBATSULY: Your Honor, I think the starting

point on this is the North Jersey Brain and Spine case from the Third Circuit from 2015, and I think that really did significantly change the viability of the argument that we just heard from defense counsel. You know, North Jersey Brain and Spine made it clear, reaffirmed that benefits under an ERISA plan are assignable. Reaffirmed Congress' intent that ERISA protect the interest of participants and that, you know, this is a policy decision of the Third Circuit.

Assignment of ERISA claims to providers, according to North Jersey Brain and Spine, serves the interest of patients by increasing their access to healthcare.

So I think the take-away from North Jersey Brain and Spine is that we're going to do away with these real form over substance arguments. And very clearly the court held: An assignment of the right of payment is sufficient to confer standing to sue for payment under ERISA 502(a)(1). That is the denial of payment claim that I think I'm hearing counsel is now conceding -- our assignment does do that.

But our assignment does go much broader. And I think she's -- counsel is suggesting that while it may be good enough for the benefit claim under 502(a)(1), you know, it shouldn't be good enough for the fiduciary duty claims. And here's where I respectfully disagree. The assignment here goes broader than what North Jersey Brain and Spine found sufficient, and it covers all rights, benefits, privileges, protections, claims,

causes of action, interests or recovery arising out of any plan.

And North Jersey Brain and Spine did overrule Meadowlands, the MHA case that was relied on heavily by defense counsel. There, the court had distinguished between -- made really what I would respectfully call a form over substance distinction. The court had held that assignment of a right to payment and an assignment of plan benefits are two different things, and that only an assignment of plan benefits was sufficient. North Jersey Brain and Spine did away with that distinction and made it clear that, like I said, an assignment of the right to payment is alone sufficient.

Ours does that and much more.

With respect to the claim that we have an inconsistency in the assignments, I again have to disagree. The Authorized Representative section simply designates the CarePoint Hospital as an authorized representative relating to all subscriber's rights, benefits, privileges arising under the Plan. That does not in any way undercut the assignment in the first instance of the subscriber's rights to his or her -- all of her rights, benefits, privileges and protections arising under the Plan. And I would note that in North Jersey Spine, the language of the Plan that was the issue had language that is now being criticized by counsel in this case. That language, just as here, had authorized the provider that an

appeal to my -- appeal to my insurance company on my behalf, at the same time it also assigned to the healthcare provider payments for medical services rendered to myself or my dependents. The court didn't cite any inconsistency with those two clauses and upheld the validity of the assignment at least as to the benefits claim.

And I think, you know, I have not found any cases either that would support the argument that defense is advocating -- that just because you include an authorized representative section so that it's clear that the person who's taking the action is the hospital -- I have not found any cases that take the position that that somehow extinguishes the assignment the first instance. I think the argument is foreclosed by North Jersey Brain and Spine.

THE COURT: I'm just curious. In terms of all the agreements that you have, do you have the authorized representative language in all of your agreements?

MR. BARBATSULY: We have a form that we pled, and the typical form has both clauses in the assignment of benefit form.

THE COURT: Okay. Thank you.

MS. BJORKLUND: Your Honor, I would like to respond to the New Jersey Spine point.

So, first of all, I would point out that the fact that the court didn't independently identify this argument of a

conflict between assignment and authorized representative clauses does not do anything for the argument that's presented to this Court. Some of the facts may have been similar but the argument was never presented and it was never decided, and that case certainly doesn't dictate a result either way.

The other thing I would point out about New Jersey Brain and Spine is the language that that opinion makes clear. They're talking about a claim for benefits, a 502(a)(1)(B) ERISA claim.

I didn't see anything in the opinion that suggested a breach of fiduciary duty or other type of ERISA claim or a state law claim. It really was focused on the idea of whether assignment of the right to payment assigned the ability to bring suit to enforce that specific payment, which is obviously very different from our case which has 11 causes of action.

The other thing I would point out is, we cited the MHA case for a very basic proposition, which is just when you give up a right, then the patient no longer holds that right. That continues to be good law. That was in no way overturned by New Jersey Brain and Spine. And I am aware of ERISA opinions in this District issued in the last year that have actually cited MHA for a similar proposition, noting that New Jersey Spine abrogated it on other grounds. So I believe that MHA still is good law for the point that we use it for.

And the final point I make on this is just, CarePoint

is in charge of its own forms. CarePoint can choose whether it wants the claims to be assigned or whether it wants to be an authorized representative. But it has to choose, it can't be both. Because when it's both it's ambiguous in the terms of the Plan and then renders it ineffective. So it's not a question where they're presented with some terrible issue. If they want to be an authorized representative they can draft their form that way; if they want to be an assignee, they can draft their form that way, but they can't do both.

I'll move on to --

THE COURT: Let's just get a response to that and we'll move on the next issue. Thank you.

MR. BARBATSULY: Well, you can do both. And to the extent that there is any arguable conflict, keep in mind that the Authorized Representative section only applies to all of my rights, benefits, and privileges. And if we're getting really hypertechnical, which I think we can't do under North Jersey Brain and Spine, the way to harmonize those provisions is to the extent that the assignment didn't cover any rights, the authorized -- and I'm not suggesting I adopt this -- but I'm suggesting that to the extent there is a conflict, which I say there isn't, that the assignment controls. The assignment extinguishes the patient's rights and they belong now to the hospital.

So one could read this as sort of a fallback, that to

the extent there are any residual rights that the patient has that are not extinguished by the assignment, those are the -- the hospital is still authorized to proceed. But there's no inconsistency.

And again, coming back to the North Jersey Brain and Spine, that exact authorized rep language or very similar authorized rep language was in that assignment and the court did not even address it, there was no issue. And there is not a single case that either of us have found that would support the defense's reading of the authorized rep language to somehow extinguish or be inconsistent with the assignment language.

THE COURT: Okay. Anything? Last point on that.

MS. BJORKLUND: No.

Just to clarify: I haven't found any case that specifically addresses this argument either way.

THE COURT: Okay. Fair enough.

What's the next position?

MS. BJORKLUND: So, I just wanted to talk about the anti-assignment clauses.

THE COURT: Yes.

MS. BJORKLUND: These apply to Patients 1 and 2 and any other unidentified patients that may be encompassed in this Complaint that have an anti-assignment clause.

Our brief cites to the general anti-assignment rule, and the Court's opinion in Cohen v. Independent Blue Cross/Blue

Shield, Advanced Orthopedics, and so on -- I'm sorry, that might be -- recognize that an anti-assignment claim can be enforceable in New Jersey as well as in other places.

Then because the anti-assignment -- they've now made this counter argument that there's waiver. I would point out that again we go back to the authorized representative language. So these forms that the patients allegedly signed have both the assignment and the authorized representative language. And it's a little bit curious that -- I mean, I suppose the argument would be that United should not have communicated with the hospital even though there was the existence of this authorized representative form. I would contend that United was acting in accordance with the authorized representative form in having this communication; or, in communicating in CarePoint's capacity as a provider, and that this correspondence in no way waives any anti-assignment right.

There's also -- and we cited this in our brief -- one of the Plans has a waiver provision saying waiver of any one provision at one point doesn't lead to waiver of that same provision at a later point or any other waivers of any other piece.

One other point I would just make about the Middlesex case. In their opposition brief, Plaintiffs state that the Middlesex case is not helpful on the point of waiver because it

doesn't involve an anti-assignment clause. And I would contend that that makes Middlesex even stronger for our case. Middlesex addressed whether there was a waiver of an argument that an assignment was not valid even without an anti-assignment clause. And so if the activity was not a waiver even in the absence of an anti-assignment clause, it's hard to see how it would be a waiver in the presence of a very specific anti-assignment clause.

THE COURT: Okay.

Counsel.

MR. BARBATSULY: So, I'll make an argument that at the outset we think, as we said in our brief, that we think the statute that we cite, New Jersey Statutes Annotated 26:2S-6.1(c), that alone, we would respectfully submit, renders anti-assignment clauses unenforceable in New Jersey as a matter of law. I would just respectfully refer your Honor to the Appellate Division case we cited, New Jersey Dental Association v. Horizon Blue Cross/Blue Shield. And I won't belabor this point, I recognize your Honor and Judge Wolfson have reached a different view of this in the Advanced Orthopedics case, and I believe Kaul v. Horizon, so I won't belabor the point. I would just respectfully ask that your Honor take a second look at that in light of the policies that are now articulated in the North Jersey Brain and Spine case. So that's my first argument, the first argument we raised in the brief.

But more fundamentally, I guess your Honor doesn't necessarily have to reach the issue of enforceability of anti-assignment clauses as a general matter post-North Jersey Brain and Spine, because as the cases we cite indicate or make clear, that such clauses can be waived by a course of business dealing.

Let's back up though for a second. Because the anti-assignment clauses, there's really only one anti-assignment clause that's at issue and that's the clause in Exhibit L, the Plan that's Exhibit L. The Plan that's in Exhibit O says essentially, you know, rights can be assigned only with the consent of United. So I think that's a little different. And we plead -- and we'll get into course of dealing -- but the course of dealing that we plead we think is sufficient to amount to a waiver across the board.

But certainly with respect to Exhibit O, we contend specifically that that particular clause gives the Plan the right to consent, and the Plan did consent through its course of dealing.

But more fundamentally, the Premier Health case that we cite, a 2012 Westlaw case, 1135608 (D.N.J. April 24, 2012), the course of dealing that was alleged was very similar to what we have in this case. It included specifically letters notifying Premier of overpayment. We have those here. Demanding a refund. We have those here. Notifying Premier of

the proper procedure to dispute HealthMed's decision.

Well, if we have notices of a procedure, we say that it's not the proper procedure.

Telephone calls between HealthMed and Premier. We have telephone calls and emails here.

Communications with Premier via email. We have those here.

And then the court in Premier said: Such actions impede United or HealthMed's ability to rely on the anti-assignment provisions to challenge Premier's standing.

I can go through at length our Complaint details, exhibit through exhibit, detailing an extensive course of dealing. Starting with Exhibit A, an email exchange; Exhibit B another email exchange; Exhibit C and D, spreadsheets setting forth recoupment demands, actual recoupments starting some time around November; Exhibit F, audit findings; Exhibit G, another email exchange; Exhibit H, and appeal resolution letter; Exhibit I, another appeal resolution letter. I can go on and on. In none of the correspondence is there any implication whatsoever of a bar or a refusal to speak to us based on an anti-assignment clause.

And I recognize your Honor has recently written -- or more recently than a briefing written on this issue in the case, Kayal Orthopaedic Center v. Empire Blue Cross/Blue Shield, 2017 Westlaw 4179813 (D.N.J. September 21, 2017). In

that opinion, your Honor acknowledged the case law that addresses course of dealing. And in that particular case your Honor said: (Reading) Plaintiff here fails to allege the sort of routine and ongoing course of dealing which might otherwise support an argument for waiver. Outside of direct payment, the only conduct which plaintiff asserts demonstrates a course of dealing was defendant's written response to appeal efforts.

An assertion of waiver based on an isolated communication is distinct from the level of ongoing engagement at issue in the DeMaria and Gregory Surgical Service cases that your Honor had action acknowledged.

And we submit that we have far more than an isolated communication. We have a whole litany of communications that I just alluded to.

So that is a course of dealing that's inconsistent with the enforcement of any anti-assignment clause, even the one in Exhibit L.

And I will note, counsel relies on an anti-waiver provision in Exhibit L. That doesn't say what counsel says it says. It simply says: The waiver by any party of any breach of any provision of the Certificate will not be construed as a waiver of any subsequent breach of the same or other provision.

That's different from the waiver of a contractual right to an assignment. There's no allegation of a breach except by us. But there's nothing in there that says a waiver

of -- or direct communication counts as a -- doesn't count as a waiver.

And even if that did count, your Honor, I would submit that this whole -- this case law and this extensive course of dealing does foreclose the argument at this stage for -- for relying on that alleged anti-assignment clause. And of course, like I said, that only applies really to one Plan. The other Plan has sort of a carve-out for consent. Two of the Plans that we attached to the Complaint don't have any anti-assignment clause, and it remains to be seen in discovery what the other Plans at issue are. They haven't identified any other anti-assignment clause.

So I would submit that at a minimum that issue is not appropriate for resolution here on this motion. But I think -- and we've certainly alleged more than we needed to with respect to course of dealing.

THE COURT: Okay. Thank you so much.

Counsel has indicated that he's provided ample evidence, pointed to ample evidence and has sufficient pleadings with respect to waiver. And he's not just relying upon direct payment, he has a whole course of dealing including emails and telephone conduct and a litany of things. How would you respond to that?

MS. BJORKLUND: I would say, your Honor, all of that communication is perfectly consistent with the idea of an

authorized representative. It can't be that by communicating with someone who is an authorized representative pursuant to assigning a patient document, an insurer like United is then waiving any anti-assignment clause or any right based on assignment. So the Authorized Representative portion of that agreement means that United can communicate with the provider, and that's exactly what it did.

Even aside from the Authorized Representative portion, United is certainly free to communicate with a provider as to disputes between the two parties. As to, obviously in-network providers have an independent relationship with an insurer or a claims administrator, but also even out-of-network occasionally there are agreements between those entities, and it's not inconsistent with the terms of a Plan to have communications like that.

I would also say that the waiver, to address the point about the waiver provision in Exhibit L, the breach of a provision is the anti-assignment provision. The anti-assignment provision says you won't assign your claims, and if you do it's not valid.

And so by assigning claims, that's the breach. And so a waiver of any breach isn't a waiver of anything -- any other right to assert that same breach.

The other point I would make is that plaintiff now contends that since only some of the Plans at issue have

anti-assignment, that the Court shouldn't address it now. I respectfully disagree. In my experience, a court can rule on this issue as to certain patients and thereby narrow the issues, and when later Plans sort of come to light if this case were to proceed --

THE COURT: Although we have over 400 patients at issue here. Are we going to go through each one --

MS. BJORKLUND: We have over 400 patients. We know 423, or whatever the number is, claims. We don't know the overlap of the patients, we don't know how many Plans are at issue.

THE COURT: But just by the very nature of what you just said, how is the Court going to parse through that now?

MS. BJORKLUND: So the Court would not be able to rule as to a certain number of patients or a certain line item of claims, but it could certainly rule as to the two Plans in front of it and issue a ruling that would make a similar ruling as to any other Plans with similar language. That would then be presented to the Court on kind of an early motion or some other proceedings as the Court sees fit so that there isn't this wasted expenditure of Court resources to do discovery and can resolve claims that actually shouldn't be in court in the first place. But I submit that also is an option as to exhaustion. If the Court were to believe that factual development is necessary, that can proceed without other more

rigorous or extensive or time consuming for the Court aspects of the case.

THE COURT: Okay. Let's hear a response from the plaintiff.

MR. BARBATSULY: So, two things. As for the allegation that what they were doing in dealing -- communicating with us was consistent with an authorized representative versus an assignment, there's no evidence from any of the correspondence that they were relying on solely on an authorized representative versus an assignment. In fact, there was no discussion of that issue one way or the other. So to suggest that, well, no, we didn't waive it because we were only looking at the authorized representative form and not the assignment form, that's really not an issue before the Court and not an issue that the Court can decide for purposes of this motion.

And that's with respect to -- and with respect to Patient 1, the No Waiver Clause, they interpret it as the assignment is the breach versus a right.

Again, those are fact issues. Those are going to be issues of interpretation of the Plan that are really appropriate for -- not appropriate for a motion-to-dismiss phase. The settled rule for interpreting ERISA plans is contra proferentem, meaning that you can construe the Plan terms against the drafter of the Plan.

And so I don't think on this record it's appropriate, certainly not with respect to the 423 claims, but not even with respect to a single claim to make a broad pronouncement as to the import of these isolated plan provisions without the benefit of discovery, and particularly in the face of this extensive record that is attached to the Complaint of dealing with our clients without so much as a hint of an anti-assignment clause issue.

THE COURT: Unless there's anything else on this, I would like to discuss fiduciary duty.

MS. BJORKLUND: Just one minor point.

THE COURT: Yes.

MS. BJORKLUNDI: I would say that actually silence in the record weighs against waiver and not in favor of it. And general waiver is a voluntary relinquishment of a known right. And continued course of communication is consistent with authorized representative. And silence on the point of assignment I believe would actually counsel against a waiver argument.

THE COURT: Anything else on that, Mr. Barbatsuly?

MR. BARBATSULY: Well, I just refer back to the extensive record that we have and the case law that makes it clear what a course of dealing is that would amount to a waiver.

THE COURT: Okay. Let's move on.

Thank you.

MS. BJORKLUND: If I could very briefly address Count 2 and failure to state a claim.

Our primary argument is that Plaintiff CarePoint has not adequately pleaded that United is a fiduciary under ERISA. There are a number of cases saying that processing claims or being a claims administrator is not sufficient, that it requires some additional exercise of discretion.

I would note that by default under ERISA and Plan terms, the Plan administrator is the Plan sponsor. So it's a little confusing. There's a Claims Administrator and a Plan Administrator. And the Claims Administrator processes the claims; the Plan Administrator is in charge of, in a bigger discretionary function as to kind of developing and implementing the Plan itself.

And so this breach of fiduciary duty claim goes against the Plan Administrator, whereas really it's the documents and the record and ERISA's underlying presumption indicating that United is not the Plan Administrator, it would be the Plan Sponsor, meaning like an employer in most instances. This is an issue that's appropriate to be resolved on a motion to dismiss. I point you to a case cited in our brief. See the Ambulatory Surgical Center of New Jersey v. Horizon Healthcare case. It's 2008 U.S. District Lexis 13370. And I'll leave it at that.

THE COURT: Okay. Anything on this?

MR. BARBATSULY: So, as far as the precise role that United now claims it stands in, we cited a number of cases, including Chao v. New Jersey Licensed Beverage that make clear that fiduciary status is a fact-intensive inquiry making resolution of that issue inappropriate for a motion to dismiss.

And our claim in Count 2 is a claim for appropriate equitable relief under the relevant section of ERISA that would be available to redress a fiduciary duty breached. And the lead case, the case that we cite on that is a Third Circuit case, Hahnemann University Hospital v. Allshore, Inc., 514 F.3d 300 (Third Circuit 2008). The court upheld and, in fact, upheld in the context of an assignment that the reviewing of the record supported a finding that the defendant had breached a fiduciary duty that it had owed to the plaintiff as an assignee of the patient.

So the claim is clearly permitted. And whether United is a fiduciary or not by virtue of it's very varied roles is really not something that this Court should decide on this record. A fiduciary though, again the case law is, it's a function not a form determination. And so we contend functionally United did act as a fiduciary in making all the discretionary decisions, including the decisions ultimately to recoup substantial sums of money from our client.

THE COURT: Okay. Thank you.

How does the Defendant respond in terms of, first let's address whether a healthcare provider can pursue a fiduciary duty claim and address it in the context of the case law which appears to allow those claims to go forward?

MS. BJORKLUND: So, I guess this goes somewhat back to the assignment issue. Right? So if there is a valid assignment of a patient's right for an (a)(2) breach of fiduciary duty claim, then since the provider is holding that right it would seem that the provider can assert the right of the patient if the provider in fact holds that right. Now, that's different than saying a provider can assert its own breach of fiduciary claim for a breach of fiduciary owed to it. It would be in the context of a duty owed to the patient, not to the provider.

Going back to the issue of whether fiduciary duty status can be resolved on a motion to dismiss, again I would direct your Honor to the Ambulatory Surgical Center case. I think that really touches on this precise issue and ruled that it was appropriate on a motion to dismiss. But to say as to who is the plan, there are two ways that I can think of that they can adequately plead this, but they haven't done either. So they haven't adequately pleaded that United is a plan sponsor. Even if there is a vague assertion in the Complaint, it's contradicted by the underlying documents and by the statute ERISA itself.

And then the second point is, the cases note that you can plead specific facts to establish a fiduciary duty, but a fiduciary duty is a question of law. You can't simply plead that there is one, you have to plead specific concrete facts under Twombly that would allow the Court to see that there is, in fact, this duty, and that is simply lacking from the Complaint.

THE COURT: Thank you.

Anyone?

MR. BARBATSULY: I'll just say that we don't have to plead that they were a plan sponsor, we just have to plead that they were a fiduciary. And any party that has any discretionary role in a claim's decision is a fiduciary. So it's not, again, not a form issue, it's a functional issue.

MS. BJORKLUND: Can I just clarify one point?

THE COURT: Certainly.

MS. BJORKLUND: Fiduciary duty status is a legal question. It's a legal conclusion and needs to be pleaded with specific facts. One way to plead that fact is by trying to allege a plan administrator, and that was my point in that instance. But other than that there are no other pleaded facts to support a legal conclusion of fiduciary duty.

THE COURT: Okay. Although I will point out that there are several cases, for example, Neurosurgical Associates of New Jersey PC v. QualCare, for example, this is a quote:

ERISA fiduciary status is highly fact-based dependent upon tests performed by the individual or entity. Thus, rulings on this issue have tended to occur after discovery rather than at the pre-discovery motion to dismiss stage, closed quote. And there are other cases which echo the same sentiments.

MS. BJORKLUND: So, your Honor, I would acknowledge that the cases take different positions. I mean, I do think Ambulatory Surgical, not to be a broken record, is the most precisely-on-point case and does resolve on a motion to dismiss. I think two are two issues. First, one is pleaded. Because as Twombly says, we can't plead a legal conclusion, you have to have specific concrete facts to back it up. And then the second is: Is there enough of a factual dispute, a factual dispute about whether these actions occurred or they rise to the level of fiduciary status. And that I think is what the cases that you referenced are really more talking about. But this Complaint is devoid of specific allegations that would give rise to a fiduciary duty status.

THE COURT: Okay. Anything else on this before we move forward with the next point?

MR. BARBATSULY: No, your Honor.

THE COURT: Thank you. All right. What do we have next?

MS. BJORKLUND: Your Honor, I will move on to the state law claims unless there's anything else you would like to

address.

THE COURT: That's fine.

MS. BJORKLUND: So, from the face of the Complaint it appears that CarePoint concedes that Counts 4 through 6 are preempted.

THE COURT: Actually before we do the state court claims, let me ask Plaintiffs: I think they're pled in the alternative. Correct?

MR. BARBATSULY: That's correct. So we did make a point in our brief that we're not pleading the state law claims to the extent that they are directed to any ERISA plans.

THE COURT: Are you asking this Court then to construe those claims, or only in the event you are not successful on the federal claims?

MR. BARBATSULY: Well, at this point we've pled that we have a number of claims. The Plans that we've attached to the Complaint appear to be self-funded ERISA plans, so obviously those would be ERISA claims for which our state law claims would not be actionable. But we have requested and have not gotten, and we would hope to get in discovery, all of the Plans. So really the state law claims would arise to the extent you have a Plan, for example, an individual insurance policy that's not governed by ERISA, not an employee benefit plan, that would be governed by state law.

THE COURT: Let's go back to just the very basic

question. In terms of the Plans, do you have and are you alleging non ERISA plans for those state court claims?

MR. BARBATSULY: We have not seen plans that are covered -- that are not covered by ERISA, but we have identified 423 claims in the Complaint that are at issue. United is in control of the information as to whether those are ERISA plans or not ERISA plans. United hasn't come forward obviously at this stage. I'm not suggesting that they had to, but that issue has not been fleshed out in discovery. But we would be pleading these claims to the extent that those -- any of those 423 claims are individual policies of insurance that are not governed --

THE COURT: How do you suggest at this point, if we're uncertain as to whether they are non ERISA plans at play, how would the Court deal with this issue from the Plaintiffs' perspective.

MR. BARBATSULY: From the Plaintiffs' perspective, what I would suggest is, as part of the I guess the initial disclosure process, assuming obviously that we can get past the motion on the ERISA claims which we believe we should, that as part of the initial disclosure process, that United be directed to produce every single plan that governs every one of the claims in our case. At that point both parties are going to be more informed as to, if to the extent that your Honor does -- and I recognize, I don't want to push the burden on the Court

with hypothetical claims that may not ultimately --

THE COURT: That's what I'm getting at. If we're not really dealing with non ERISA claims, do we really need to address those state claims at this point?

MR. BARBATSULY: From the Plaintiffs' perspective, we would be amenable to deferring that decision pending discovery of the full Plans. I mean, our argument is that these are all ERISA plans, and so to the extent that United says, not so fast, you don't have an ERISA claim with 50 of these plans because they're state law claims, we have those claims in the alternative.

THE COURT: Okay. Let me ask counsel: Are there any Plans here at issue that are non ERISA? And how should we deal with this issue of the unknown at this point?

MS. BJORKLUND: Your Honor, I don't have an answer on whether there are any non ERISA plans potentially at issue. I point out that this whole colloquy illustrates the divide between CarePoint, the Plaintiff in this case, and the patients whose rights they are supposedly vindicating. But the patients do have copies of their own Plans, they have to be provided every year under ERISA, and yet CarePoint doesn't have those.

So we would submit, Defendants would submit that those claims should be dismissed at this time. It's not sufficient to simply plead a cause of action when you think you might come up with facts that might support that cause of action. You

have to have concrete facts at the time of a motion to dismiss.

Now, the federal rules also allow for amendment of pleadings in certain circumstances when appropriate, and I think that would be a much more appropriate venue than allowing claims to proceed when Plaintiffs acknowledge that they are not aware of the existence of any non ERISA plans.

THE COURT: Okay. In terms of this, I'm thinking if we did go down a path such as that and permitted an amendment, normally you'd amend within a certain period of time. I'm not certain how much time you would need to determine -- I'm going to ask the Plaintiffs -- to determine whether you have non ERISA plans.

MR. BARBATSULY: Well, I think that depends on United since -- I mean, counsel has made an extra record fact that the patients have all the Plans.

We've alleged in the Complaint -- and that's what we have in front of the Court -- that we have a handful of Plans that were produced in pre-suit discussions. We don't have all of them, and we think that those should be provided and then we can discuss a schedule for that and then a schedule for -- to the extent we -- I don't agree dismissal of the state law claims is warranted at this point because we do have the right under Rule 8 to plead in the alternative, and that's what we've done.

But to the extent --

THE COURT: But in terms of pleading to the alternative, is it pled that you have non ERISA plans?

MR. BARBATSULY: No. It's pled that to the extent that any of the Plans covering these 423 patients are not ERISA plans, then they are governed by state law. So that's the alternative theory. But that's a fact, that's not -- at this point as between the parties in this case, only United has those facts at this point.

So we've pled --

THE COURT: Although they're saying, well, you should be able to get them through the patients.

Should you be able to get those through the patients?

MR. BARBATSULY: Well, we don't necessarily have -- well, logistically whether each patient would cooperate, we're dealing with claims that are now eight, nine years old, that's an issue. But we should as assignees of the patients' rights under the Plans, we should be able to get them from United. And those are documents that ought to be, and in our experience in these cases, are provided in discovery.

And so to the extent that there's any decision to defer, I would submit that the decision would be premised on United providing the Plans and then having the parties reviewing those Plans and assessing which -- the extent to which any are non ERISA plans at that point.

THE COURT: And let's go back to this: If they are

all ERISA plans, then do you submit that those state court claims would not go forward?

MR. BARBATSULY: If they're all ERISA plans, then -- well, I shouldn't say categorically. But I think with the particular causes of action that we've pled, that they would not be -- they would not go forward because they would be preempted by ERISA. ERISA does have a carveout for state statutes, you know, governing the insurance company insurance industry. We haven't pled at this point any claims arising under any specific state statute.

So I would submit that -- I would agree with your Honor that to the extent that there are no non ERISA Plans -- which I think is highly unlikely, by the way, because just given the number of claims -- but to the extent that there are none, then we would not be pursuing state law claims.

THE COURT: And as far as the earmarks of a non ERISA plan, what would it be, governmental or some other plan?

MR. BARBATSULY: Yes. Any plan that would not follow the definition of an employee benefit plan under the ERISA statute. So that would include a government plan, it would include an individual policy of insurance, that's saying an individual who doesn't have insurance through his or her employer, you know, got off of the exchange, for instance. And there are plans of that nature as well and we have just don't know the extent to which that's gone on here yet.

THE COURT: Okay. Let's get a response.

MS. BJORKLUND: So, your Honor, I think this narrows the issues significantly if there is a confession that the state law claims don't go forward unless there is existence of a non ERISA plan. I mean, I would agree with counsel's assertions.

Do you want me to go into specific alternate reasons for dismissal? Or if there is something you would like me to discuss --

THE COURT: If there's anything else you feel you would like to amplify beyond what's in your papers, you may do so. Go ahead.

MS. BJORKLUND: Thank you, your Honor.

So there are seven state law claims, and I won't torture all of us by going through every single one of them.

THE COURT: As I said, I read the papers. So if you would like to go through the highlights, that would be fine.

MS. BJORKLUND: Right, exactly.

So one point I would like to make is, Count 8, the promissory estoppel claim, which is supposedly based on a promise made during an unidentified, undated phone call with no quotations. And this is based on paragraph 162 of the Complaint. The allegation and a supposed promise made by United is that certain claims are covered under the Plan. And as we've discussed many times, there's an issue of coverage and

then there's an issue of extent of coverage. And this case really focuses on extent of coverage.

So an assertion that a particular type of claim or type of benefit or type of medical service is covered under a plan is very different than a dispute as to whether the amount paid by United complies with the terms of the plan in comparison to the amount that Plaintiffs are charging. So that's all on Count 8.

THE COURT: Anything on that?

MR. BARBATSULY: So, with respect to Count 8, and we do allege that there is a clear and definite promise in the sense of course of paying claims dating back to 2010. The allegation that we haven't relied on the claims because, number one, for emergency we have no choice but we have to treat the patients who come to our doors in emergency situations. Obviously that rationale doesn't apply with elective patients. But the other more fundamental issue, because of this extensive delay and the paid claims dating back many years and now claiming years later we did it wrong, you owe us hundreds of thousands of dollars, we're not in a position -- or we're in a much worse position by this conduct based on the fact of this delay and this now sort of pulling the rug out from under us. So that we think is the essence of a promissory estoppel claim.

And I do want to kind of qualify one thing I said earlier. We don't -- we're not pursuing these state law claims

to the extent that they are governed by ERISA plans. But I will say the Broad Street case that we cited and that defense counsel cited, that was a case where the court found no standing based on an ERISA plan but found a -- recognized the existence of a promissory estoppel claim based on an independent promise to pay. And so to the extent that the defense is going to argue that we somehow lack standing for a particular claim even if it was an ERISA plan, we would want to have a full-back argument based on the Broad Street case that we had a promise notwithstanding the extent that we didn't have standing.

So that would be my only sort of qualification to what I said earlier. That even if there is an ERISA plan in play but defense argues and is ultimately successful in arguing that we don't state a claim under the plan, we would have this fall-back promissory estoppel claim per the Broad Street case.

THE COURT: Okay. Anything on that?

MS. BJORKLUND: So, your Honor, I just point out -- and I apologize if I'm misunderstanding what he's saying -- but for a promissory estoppel claim, I mean there could certainly be a preemption issue to the extent the promissory estoppel claim is dictating the level of insurance benefits under an ERISA plan, and I think that would still exist. But otherwise I understand his point, but he's basing it on other communications outside of the plan. But again, I would submit

there is a preemption issue.

THE COURT: Before we go any further, tell me which ones are the state court claims if you would like to read off the numbers.

MS. BJORKLUND: 4 through 11.

THE COURT: 4 through 11. Okay.

MR. BARBATSULY: Just for clarification, the quantum meruit claim, we didn't substantively oppose the motion as to that particular claim, so we're not -- to the extent that we do go forward with state claims, we are not going to be pursuing that claim.

THE COURT: Okay. That is number what?

MS. BJORKLUND: 7.

THE COURT: Number 7.

MR. BARBATSULY: 7.

THE COURT: I don't know if you would like to send in a letter or something to that extent.

MR. BARBATSULY: That's fine, your Honor.

THE COURT: Great. So that's Number 7 you're not going to be pursuing.

What do we have in terms of the injunctive relief, Count 9?

MS. BJORKLUND: So, your Honor, one argument we made in our brief is that there are not any allegations related to irreparable harm or public interest or some of the other

factors that are required for injunctive relief. Also, there remains a preemption issue. And I would point the Court to the relief sought at the end of the Complaint, which is very broad and applies to -- apparently applies to any claims by the affected patients who assign their rights, or any other patients who didn't assign their rights to CarePoint of those same Plans and of going forward prospectively for any future claims as coming from CarePoint.

So again, we think that the standing and the assignment issues are particularly important to that injunctive relief claim because it does have such a broad impact.

THE COURT: Okay.

Mr. Barbatsuly.

MR. BARBATSULY: And I'll just point out that the cases we cite, including the McGee v. Continental Tire and as to the declaratory relief claim and the First Choice v. Wendy's case as to the injunctive relief suggest that these are discretionary remedies that are ordinarily not appropriate for resolution at the early stages. So we have these claims, and there are facts that have to be developed in discovery.

In the First Choice case, for example, as to injunctive relief, the plaintiffs asserted that they were seeking injunctive relief as an ancillary remedy and that they do lack an adequate remedy at law. The court said, at the early stage of the litigation and based on the allegations, the

court is not inclined to foreclose the injunctive relief as a possible remedy.

I would submit that at this stage your Honor should leave both the declaratory and injunctive relief and defer decision on those until later in the case.

THE COURT: Until later in the case?

MR. BARBATSULY: Yes, until later in the case, your Honor.

THE COURT: Okay. And in terms of that, are you saying that as part and parcel of just we need not address it at this point because it's the ultimate relief sought?

MR. BARBATSULY: (a) because I think the inclination is to defer decision on the state law claims pending further discovery, we would request discovery as to the Plans; but (b) even assuming that we move forward, those are types of relief that the Court would typically fashion really at the end of the case after all the proofs are in and the Court decides whether it needs any kind of broad declaratory relief to impose to protect the parties' rights or injunctive relief.

And, by the way, those types of claims, similar arguments -- we have similar claims in the ERISA context as well, that the declaratory and injunctive relief are available under ERISA. And so, again, we would submit that that decision as to where to impose broad declaratory, broad injunctive relief is not for now, it's for later in the case after all the

proofs are in.

THE COURT: I have a question about deferring versus dismissing without prejudice with a right to replead after discovery. Is there any true distinction between those two?

MR. BARBATSULY: Well, the distinction is that had we adequately pled state law claims, and if we have, then dismissal is not appropriate. If we haven't, then dismissal is appropriate.

We submit we have adequately pled state law claims because we've identified 423 claims. We've pled under Rule 8, we've pled in the alternative --

THE COURT: But that's what I'm getting at, in the alternative. If we don't -- I mean, you say in the alternative, if they're non ERISA plans, here are our state claims. However, do you have to go through the analysis and then say: We've identified the following non ERISA plans, and you go through at least something very, very general even to rise to the level of a sufficient pleading? Do you have to do that, number one?

And if you do have to do that, isn't that something that the Court would then be in a position to dismiss without prejudice pending your receipt of the non ERISA plans with an appropriate time period for you to replead on that so that you could state that you actually affirmatively have those Plans?

MR. BARBATSULY: I think we're sort of in a bind

because we don't control the information at this stage. United has the Plans.

THE COURT: But with the Court maybe setting a schedule for the Plans to be provided and thereafter some sort of an amendment.

MR. BARBATSULY: Well, I still think there is a difference between a dismissal even without prejudice and even if your Honor were to give leave to amend after the production. But I think the real question is, on this pleading, have we stated state law causes of action.

And I respectfully submit that on this pleading we have, and we've done it in the alternative. So I would submit that that is an appropriate -- we have pled these appropriately under Rule 8 as alternative claims.

I would be amenable, if your Honor were not to reach those issues until it's definitive, but I don't think dismissal is the right way to go because that would imply that we had not properly pled the claims, and I think we have.

THE COURT: Okay. But is it enough just to say: "And if we have any non ERISA plans," if you actually haven't pled that you have those?

Generally you see an alternative pleading. Someone says -- not in this context but in other contexts -- oh, it's a breach of contract and in the alternative it's quantum meruit, and that's an alternative pleading. But if this is based on

some scenario, and we're not even sure we have the scenario, do you have to be a little bit more specific in order to have those go forward?

MR. BARBATSULY: Certainly on the promissory estoppel portion under the Broad Street case I think that is a viable claim as an alternative even without knowing whether there's a state law plan in play because --

THE COURT: But if we're looking at the state law claims as a block, how are they going forward if we don't have the allegations that there are non ERISA claims? That's really the question.

MR. BARBATSULY: Well, we do have allegations that to the extent any of these 423 claims are not governed by an ERISA plan, then by default they're going to be governed by state law, and just given the shear number. I think your Honor can plausibly infer that the likelihood is that at least some are state law governed claims. But again we don't -- we're not going to know that until we get the Plans.

So I don't want to belabor this because I don't know that ultimately it makes a whole lot of difference. But I do think -- I come back to: We think we've plausibly alleged the existence of state law claims as -- you know, as an alternative to -- you know, and to the extent that any of these 423 claims are not governed by an ERISA plan.

THE COURT: Okay.

Counsel.

MS. BJORKLUND: Your Honor, a few points on that. I point out, they do not allege the existence of a single non ERISA plan. And they're vindicating rights on behalf of patients who receive ERISA plan disclosures every year.

It appears that counsel has conceded that --

THE COURT: Do they need to, or is it just enough to say -- their exact language is: To the extent that some of the Plans are not employee welfare benefit Plans governed by ERISA, they are nonetheless valid and enforceable insurance contracts.

Is that enough?

MS. BJORKLUND: I would say, your Honor, there must be -- there are a number of missing allegations then. If they don't have access to the Plan, don't know whether it's ERISA or not, obviously can't know anything about the terms of it. They can't plead a specific entitlement to state law relief based on a breach of contract in that aspect. I mean, I think that it's one thing to say: Here is a specific given set of facts and there are alternate legal theories. But what they're saying is, there may be alternate facts and they just don't know.

It would be equivalent to saying: So-and-so said X. But to the extent so-and-so also said Y, we have another cause of action, and that's certainly not legally sufficient. So that at this point the claims should not go forward.

I have heard counsel refer to the shear number of

claims, that that creates a burden for the parties and having all these tangential issues that may actually not be applicable to anything really does impose a burden and they should at least be dismissed without prejudice for now.

We indicated a number of reasons, including for alternate bases for dismissal. But in any event, absent even the allegation of any non ERISA plan, these should not be in the case.

THE COURT: Okay.

MR. BARBATSULY: Just coming back. These are not -- these are not alternative facts, these are -- we have evidence that 423 claims were paid. They were paid under some obligation, at least ostensible obligation by United, and then United is taking the position that these obligations no longer exist and we demand a refund. So that's not made out of whole cloth. There are 423 claims for which United is saying: You owe us money.

And so they're governed by -- you know, we believe they're governed by ERISA plans. But it's not for United who has not even come forward with a single plan beyond what's been pled in the Complaint, to say, well, you can't go forward now because you don't have what we have.

And so we're saying that we've pled obligations and they're either -- they're obligations under some plan, and the plan is either -- the plans exist. They exist, they're known

to United, and they are either ERISA plans or they're not ERISA plans. That's the only fact that is missing, is whether the plans are not ERISA plans, and that's a fact that's uniquely within United's possession.

So we think we've pled at this stage state law claims. And if United wants to say, no, you haven't because we don't have a single non ERISA plan, let them come forward with the plans and then we'll revisit.

THE COURT: Okay.

MR. BARBATSULY: Thank you.

THE COURT: Counsel.

MS. BJORKLUND: Your Honor, I apologize for repeating myself, but I continue to be surprised by the assertion that these are uniquely in United's possession. CarePoint is vindicating the rights to the patient. It has the same rights to the patients and purportedly should have access to the same documents that the patients already have.

I would say that the fact that they haven't gone forward and collected those Plans and they cannot, they cannot consistent with Rule 11 actually allege the existence of a non ERISA plan, means that their case should be dismissed and they shouldn't be excused from that basic pleading requirement.

THE COURT: The other way to look at it is, he's saying, look, I have the ERISA plans. But to the extent any of them actually are non ERISA plans, that's what we're pleading.

So in the absence of discovery should he be allowed to go forward with that? And then if nothing is actually produced we probably need an amended pleading.

MR. BARBATSULY: I think if nothing that's non ERISA -- if a non ERISA Plan is produced, then I think you're right, I think that would be an amended pleading subject to my one qualification as to promissory estoppel under the Broad Street case. But, yes, your Honor.

MS. BJORKLUND: Your Honor, I think allowing the claims to continue in the case would be unnecessarily burdensome where there is no basic allegation that can support them.

I also point out that Plaintiffs' counsel articulated pretty precisely what would constitute a non ERISA plan, and it really is a fact-specific issue, governmental, that it didn't have a policy of insurance and so on. This isn't a situation where we have a complex set of facts and it's unclear which legal doctrine is going to apply. That's pleading the alternative legal theories.

This is a case where either the plan is ERISA or it's not, and it's a very simple determination, kind of along the lines of, is there a contract or not.

THE COURT: How long would it take to get these materials together?

MS. BJORKLUND: Your Honor, I would have to consult

with my client. I don't know.

THE COURT: Okay. We've had this case going on for a while. Has anyone looked at any of these Plans?

MS. BJORKLUND: We have looked at some, yes.

THE COURT: Okay. And in looking at some, what were they? Were they ERISA or were they non ERISA?

MS. BJORKLUND: The ones I've seen are ERISA. But I can't say I've seen all of them, 423.

THE COURT: Okay.

Counsel.

MR. BARBATSULY: We have only seen I think about ten, so I'm not in a position to represent if they're all ERISA. They were mostly ERISA. Obviously the four that are in our Complaint are ERISA, or we believe to be ERISA.

So I will say, as far as the burden though there's really no burden because these are just legal theories premised on a plan being governed by a different set of laws. And so the issue of the burden is really the claims themselves, the 423 claims. So once we have the claims we're going to know pretty quickly whether there are viable state law theories. Once we have the plans, I should say, we'll look, we will know whether we have viable state law claims or not.

So I don't think there's any burden on either of the parties in allowing these claims, which we think are properly pled, to go forward until we know for sure what the makeup of

the Plans are. I mean, we do know the Plans exist. The case is going to go forward under these Plans and they're either covered by ERISA or they're covered by state law.

MS. BJORKLUND: Your Honor, If I can respond.

I think we're talking about seven different claims and I think there is a difference between some of them. So as to Count 4, which is breach of contract, I agree it's a similar analysis to an (a)(1)(B) claim for benefits. But there are some state law claims that are very different and have different elements and would require different discovery and analysis and pleadings like Count 11, for example, which is based on the New Jersey Consumer Fraud Act.

THE COURT: Okay.

Let's go off the record for a moment.

(Off the record discussion.)

THE COURT: Let's go back on the record.

I've just been conferring with counsel off record regarding discussions of mediation. Counsel are going to get back to me by May 9th, one week's time, and speak to my staff about their positions with respect to mediation. And in addition to that, I've talked to counsel about determining how long it would take to compile the Plans at issue here. And they're going to go back to the clients and determine how long that process will take. And obviously we're grappling with the issue of the non ERISA plans and the ERISA plans and trying to

figure out which ones we're actually dealing with here at this point. And both counsel have indicated they have clearly seen the ERISA plan, so that is a concrete fact that has been adopted by both the Plaintiff and the Defendant.

Correct?

MS. BJORKLUND: Correct.

MR. BARBATSULY: Correct, your Honor.

THE COURT: So now we're just dealing with, are there any actual non ERISA plans at issue; and how long it would take to make that factual determination to present.

So once I hear from you we'll make a determination as to how to move forward on this. I'm going to hold on my decision at this point in time to wait to hear from you folks and then we'll figure out a way for moving forward.

With that, I ask counsel: Do you have anything else you would like to add, anything you would want to add or clarify from the argument of today?

MS. BJORKLUND: No, your Honor.

MR. BARBATSULY: No, your Honor. Thank you.

THE COURT: Thank you.

Thank you very much for your presentation, for your written presentation as well, it's been very, very helpful to me. I look forward to getting your update next week. So thanks very much.

MR. BARBATSULY: Thank you, your Honor.

MS. BJORKLUND: Thank you.

MR. JONES: Thank you, your Honor.

THE DEPUTY CLERK: All rise.

(Conclusion of proceedings.)

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